

APPLICATION FOR FEDERAL DOMESTIC ASSISTANCE - Short Organizational

Version 01

* 1. NAME OF FEDERAL AGENCY:

2. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

CFDA TITLE:

* 3. DATE RECEIVED: 08/13/1967

SYSTEM USE ONLY

* 4. FUNDING OPPORTUNITY NUMBER:

* TITLE:

5. APPLICANT INFORMATION

* a. Legal Name:

b. Address:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country:

AFG: AFGHANISTAN

* Zip/Postal Code:

c. Web Address:

http://

* d. Type of Applicant: Select Applicant Type Code(s):

A: State Government

Type of Applicant:

A: State Government

Type of Applicant:

A: State Government

* Other (specify):

* e. Employer/Taxpayer Identification Number (EIN/TIN):

StringStringStringString

* f. Organizational DUNS:

StringStringS

* g. Congressional District of Applicant:

6. PROJECT INFORMATION

* a. Project Title:

* b. Project Description:

c. Proposed Project: * Start Date: 08/13/1967 * End Date: 08/13/1967

APPLICATION FOR FEDERAL DOMESTIC ASSISTANCE - Short Organizational

Version 01

7. PROJECT DIRECTOR

Social Security Number (SSN) - Optional:

000-00-0000

Disclosure of SSN is voluntary. Please see the application package instructions for the agency's authority and routine uses of the data.

Prefix:	* First Name:	Middle Name:
* Last Name:	Suffix:	
* Title:	* Email:	
* Telephone Number:	Fax Number:	
* Street1:	Street2:	
* City:	County:	
* State:	Province:	
* Country:	* Zip/Postal Code:	
AFG: AFGHANISTAN		

8. PRIMARY CONTACT/GRANTS ADMINISTRATOR

<input checked="" type="checkbox"/> Same as Project Director (skip to item 9):	Social Security Number (SSN) - Optional:	
	000-00-0000	
Disclosure of SSN is voluntary. Please see the application package instructions for the agency's authority and routine uses of the data.		
Prefix:	* First Name:	Middle Name:
* Last Name:	Suffix:	
* Title:	* Email:	
* Telephone Number:	Fax Number:	
* Street1:	Street2:	
* City:	County:	
* State:	Province:	
* Country:	* Zip/Postal Code:	
AFG: AFGHANISTAN		

APPLICATION FOR FEDERAL DOMESTIC ASSISTANCE - Short Organizational

Version 01

9. * By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties (U.S. Code, Title 218, Section 1001)

** I Agree ☒

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

AUTHORIZED REPRESENTATIVE

Prefix: <input type="text"/>	* First Name: <input type="text"/>	Middle Name: <input type="text"/>
* Last Name: <input type="text"/>		Suffix: <input type="text"/>
* Title: <input type="text"/>		* Email: <input type="text"/>
* Telephone Number: <input type="text"/>		Fax Number: <input type="text"/>
* Signature of Authorized Representative: <input type="text"/>		* Date Signed: <input type="text" value="08/13/1967"/>

Authorized for Local Reproduction

Standard Form 424 Organization Short (04-2005)
Prescribed by OMB Circular A-102